MEDICAL BOARD OF CALIFORNIA
Background Paper For May 1, 2002 Hearing

PRIOR SUNSET REVIEW: The Medical Board of California (Board) was last reviewed by the Joint Legislative Sunset Review Committee (JLSRC) four years ago (1997-98). The JLSRC at its previous meeting considered and voted on some of the sunset issues relating to the Board. However, after the Orange County Register published its "Doctors Without Discipline" series on April 7th, the JLSRC decided to postpone hearing issues related to Board enforcement and public disclosure policies until May 1. This brief delay was to permit JLSRC staff to investigate the issues raised by the articles, to craft additional recommendations if warranted, and to provide ample time for members to question the Board at a hearing devoted to just the issues raised by the articles.

JLSRC INVESTIGATION: On April 17th, JLSRC staff provided the Board with 115 written questions addressing the following topics: patient complaints; investigations; interim suspension orders, or "ISOs;" formal disciplinary accusations; public disclosure of physician information; so-called "Section 805" reports (reports required to be filed with the Board by hospitals when the hospital disciplines a physician); and so-called "Section 801" reports (reports required to be filed with the Board by medical malpractice insurers upon payments of judgments, arbitration awards, and settlement of such claims). (Questions, Set One)

The Board has been fully cooperative with and responsive to the JLSRC's investigation. As requested by the JLSRC, on April 24th, the Board provided the JLSRC written responses to the questions and also provided several boxes of helpful, well-organized supplementary material. These answers and materials, in turn, raised some additional questions (Questions, Set Two), that the JSLRC staff faxed to the Board the morning of April 25th. As per the JLSRC's request, the Board provided written answers to the second set of questions by the close of business Monday, April 29th, and the answers to those Questions, Set Two are incorporated herein.

As well, the JLSRC obtained from the National Conference of State Legislatures (NCSL) a spreadsheet identifying the states that disclose medical malpractice settlement information and briefly describing those disclosures. The JSLRC tried to access information about physicians over the telephone and the JLSRC interviewed officials from the medical boards of states that disclose medical malpractice settlement information.

JLSRC INVESTIGATION SUMMARY: Problems with the Board enforcement and disclosure programs are not new. Many of the issues and concerns raised by the Orange County Register in early April, San Francisco Chronicle in February, and this last Monday the 29th in the San Diego Union Tribune ("Loophole Leaves Some Medical Suits Off Web Site") were

previously raised by the Los Angeles Daily News in 1994 [1] and a report prepared by the Center for Public Interest Law in April of 1989 (Physician Discipline in California: A Code Blue Emergency). Some of issues identified in this Paper are the result of Board practices and statutes many years old.

But, for some of the reasons outlined in this Paper, the problems have recently become far more urgent and exposure of the urgency in the public press has coincided with JSLRC sunset review of the Board.

An extensive review of the materials provided by the Board, the NCSL, the governing statutes, and prior reports, have revealed no single reason why the Board's disclosure and enforcement efforts have, in the Committee staff's view, justifiably fallen short of the public's trust. What is apparent, however, is that a major cause of the problem has been and remains *statutory*; that is, that the statutes governing what the Board must do in these important areas are not sufficiently clear or sufficiently mandatory to resolve identified enforcement and disclosure issues once and for all.

What is also apparent is that public confidence in the Board's enforcement program and the transparency of its public disclosure policies is thin and, if possible, getting thinner; on the verge of evolving into a "crisis." For physicians and patients it makes sense to have a vigorous, trusted regulatory program in place that prevents as many patients as possible from being damaged in the first place. It is also in the best interests of everyone concerned that this issue is decisively resolved through legislation rather than litigation or initiative. At minimum, this means (1) an enforcement program dedicated to identifying and intervening with potentially problem physicians before they harm more patients and (2) a publicly credible disclosure program that – by definition -- does not conceal from patient-consumers information they might consider important, that is available to multiple other stakeholders, and that will also permit market forces to favor quality medical care providers.

A. Every Category Of Board Enforcement Activity Has Significantly Declined Since The Last Review Even While Complaints From Patients Have Increased.

- The Board received 10,899 complaints in 2000-2001; apparently a record. This is up from 10,445 complaints in 1999-2000, 10,751 complaints in 1998-1999, and 10,816 in 1997-1998.

[1] The Daily News of Los Angeles published a series of articles that year. Two articles most relevant to this JLSRC review were entitled: "An Anatomy of Malpractice Doctors. Insurers Settled $483 Million In Claims From 1990-92. Unknown To Public" (the article details that this amount was paid in settlement to resolve 2,002 medical malpractice cases) and "Are The Public's Interests Served? Doctor's Multiple Settlements Not Disclosed In Medical Board's Records." The Daily News was able to obtain these data because of a coincidence of timing and events. The information was apparently obtained from the California Highway Patrol which was called in to investigate allegations that the Board was improperly destroying documents. The Daily News obtained the information through a Public Records Act Request similar to the one unsuccessfully sought by The San Francisco Chronicle last year.

- Accusations filed by the Board have declined.

  1998-1999= 392
  1999-2000= 290
  2000-2001= 256
  (Answer to Question 68, Set One)

- Revocations/surrenders of licenses with accusation pending obtained by the Board have declined.

  1998-1999=125
  1999-2000=122
  2000-2001=88
  (Answer to Question 69, Set One)

- Probations obtained by the Board have declined.

  1998-1999=122
  1999-2000=126
  2000-2001=107
  (Answer to Question 70, Set One)

- Interim Suspension Orders have declined.

  1998-1999=31
  1999-2000=19
  2000-2001=17
  (Answer to Question 57, Set One)

B. Few Complaints Become The Basis Of A Formal Investigation. Few Formal Investigations Become The Basis Of An Accusation. Few Accusations Lead To Administrative Hearings.

- On average, over 60% of the complaints received by the Board are from members of the public. (Answer to Question 3, Set One) "Two-thirds or 6,581 of the complaints received in FY 00/01 involved allegations of negligence or incompetence." (Answer to Question 6, Set One)[2] To quote from the Answer to Question 6: "Each of these [complaints] has a 'potential' for patient harm."

- Few complaints are referred to a formal investigation that could lead to discipline.

[2] The Board provided two different numbers and percentages on this point. The numbers from the text are from Questions, Set One. However, in the Board's answers to Set Two it stated: "The MBC reported 5,887 complaints alleging Negligence/Incompetence of 10,899 total complaints (54%)" (Answer to Question 22, Set Two)

Only about 20-25% of all complaints to the Board are referred to trained, professional investigators for the possibility of formal disciplinary action. (Answer to Question 1, Set One)

- Few formal investigations result in referrals to the Attorney General for preparation of a formal accusation (25%) (Answer to Question 50, Set One) The number of investigations referred to the AG is declining:

  1997-1998=676
  1998-1999=618
  1999-2000=491
  2000-2001=510
  (2000-2001 Medical Board Annual Report)

- Few formal accusations result in a disciplinary hearing.

  65-70% of all formal accusations are settled prior to the hearing. (Answer to Question 73, Set One)

C. 65% Of Complainants Are Dissatisfied With The Result Of Their Complaint To The Board.

- As part of its 1997 sunset review, a satisfaction survey was conducted by the Board as requested by the JLSRC. The results were alarmingly poor, showing that most of those filing complaints were highly dissatisfied with the outcome of their case (about 75%) and the overall service provided by the Board (about 60%). As revealed by the more recent 2000 survey, the Board has made some strides in attempting to maintain better communication with complainants and the recent survey seems to reflect that effort. About 80% of complainants are satisfied with the information and assistance they receive from staff of the Board, compared to about 53% in 1997, and about 53% are satisfied with the advice they receive on the handling of their complaint, compared to about 31% in 1997.

  However, there is still extremely high complainant dissatisfaction with the Board. Only about 35% in 2000 were satisfied with their overall experience with the Board (it was 24% in 1997).

D. Internal Board Practices Requiring The Routine Closure Of Most Quality Of Care Patient Complaints Likely Contribute To High Patient Dissatisfaction And Low Enforcement.

- The staff that screen and process incoming complaints (Central Complaint Unit, Staff and Medical Consultants) and decide whether a complaint should be referred to a professional investigator are explicitly instructed in writing to close *meritorious* cases that reveal an instance of *a single departure from the standard of care*, even if the departure resulted in

death or serious injury. These are classified as "Closed With Merit" cases.[3] The Board closes these cases because "[o]ne simple departure from the standard practice is NOT a violation of law." (Answer to Questions Related to Documents Provided, page 17) B&P Section 2234 generally establishes the grounds for "Unprofessional Conduct" and they are: (a) violating or trying to violate some other provision of the Medical Practices Act; "(b) Gross Negligence"; "(c) Repeated negligent acts"; "(d) Incompetence."

- The same nearly automatic closure requirement that complaints be closed, but "with merit," is applied to IME/QE[4] complaints, where a Workers Compensation examiner's conclusion, in the view of the CCU staff, "was not supported or the exam was inappropriate."[5]

- It does not appear as though the computer system used by CCU investigators or Medical Consultants contains enough detail to know whether a quality of care complaint that comes in alleges the same or similar kinds of misconduct as prior complaints, discipline, medical malpractice judgments, settlements or awards, about the same physician. This is essential

[3] Central Complaint Unit Procedure Unit Manual, Section 5.2 (Revised 1995), page 5: "IF: the Medical Consultant found a 'simple departure from the standard of care'/ THEN: close the complaint with merit."; "IF: the Medical Consultant found a 'simple departure from the standard of care/ THEN: close the complaint with merit" (Section 5.5, page 4. See also Medical Consultant Procedure Manual, page 2 (Revised 2000): "After the complaint review has been returned to the CCU staff from the Medical Consultant, it will processed [sic] according to the recommendations or findings of the Medical Consultant (i.e., closed or referred for formal investigation)" ; Medical Board's How Complaints Are Handled brochure: "If the Board finds that the physician's care fell below the standard of care but does not represent gross negligence, the complaint will be closed and will be maintained on file for the Board's future reference.") Medical Consultants working with the CCU are also instructed to close cases, but "with merit," when there is a "simple departure from the standard of care." (See Complaint Review process chart, Medical Consultant Procedure Manual) See also same, page 9: "The role of the Medical Consultant in the Central Complaint Unit is to identify whether, based on the information available, it appears that an extreme departure in the standard of care has occurred which may warrant further investigation." " page 16: "After reviewing all relevant material in the complaint file, you are asked to render an opinion as to whether the subject physician's conduct represents a potential violation of law; i.e., an extreme departure from the medical standard of practice which would warrant further investigation."; page 19: definition of "simple departure" as "negligent acts that are not considered an extreme departure"; page 20: " IF: you found a SIMPLE DEPARTURE from the standard of practice/ THEN: Prepare a memo to the CCU staff person who referred the file for MC review recommending that the complaint be closed with merit."

[4] "Independent Medical Examiner" and "Qualified Medical Examiner." These are the independent physicians used to evaluate claimed Workers Compensation injuries.

[5] Section 5.17, page 3 of the CCU Manual (dealing with IMEs/QMEs) provides in part: "IF: the Medical Consultant identifies a violation (e.g., the 'medical determination' made by the IME/QME was not supported or the exam was inappropriate)/ THEN: Close the complaint with merit." As well, same citation, the Manual states "IF: A violation is confirmed and the CCICU Manager concurs/ THEN: Close the complaint with merit."

because two of the statutory grounds for discipline --"Repeated negligent acts." (B&P Code section 2234(c)) and "Incompetence" (2234 (d)) – require proof of repeat acts. "Repeated negligent acts" speaks for itself on this score, but incompetence appears to be defined as something more than "a single, honest failing in performing [licensed] duties." (Answer to Question 11, Set Two, quoting from Kearl v. Board of Medical Quality Assurance (1986) 189 Cal.App.3d 1040, 1055. As the Board states: "That means that many of the complaints received by the Board, and do not rise to the level of an extreme departure from the standard of care, will be closed unless, and until, further allegations of negligence/incompetence are received." (Answer to Question 22, Set Two)

- This means that the unique facts of each quality of care complaint are potentially important for building a "Repeated negligent acts" or "Incompetence" case. However, "[t]he current complaint tracking system CAS (Consumer Assistance System) does not have a method of categorizing complaints in any specific manner. . .When a complaint is entered into the CAS, the Business & Professions Code Section alleged to have been violated is entered into the records." (Answer to Question 15, Set One) Likewise, while there is a "free-text" screen in the CAS that permits a CCU staff person to write in detail about what the physician is alleged to have done, there appears to be no requirement that staff do so. And, in any case, "CAS cannot sort on free-text;" meaning that one could not search for information placed there, even if it was placed there. (Answer to Question 15, Set Two) As well, complaints, like those mentioned above, that are found to have merit, but detail "only" a single instance of a departure from the standard of care, are deleted after five years, reducing the efficacy of any search or comparison of particular facts, even if those facts were routinely included and could be the subject of a search. (CCU Enforcement Manual, Section 9.13, page 2)

- Thus, when asked "to provide the number of cases in 2000 and 2001 that were closed with merit for a simple departure from the standard of practice." The Board replied: "This data cannot be extracted from CAS system." (Answer to Questions Related to Documents Provided, page 13)

- Furthermore, beyond instructing CCU staff and the Medical Consultants to check the CAS, the CCU and Medical Consultant Manuals seem almost entirely geared toward "extreme" violations of the standard of care, with little or no apparent emphasis on identifying physicians who repeatedly – but less egregiously – depart from the standard of care with the aim of possibly identifying an appropriate "Repeated negligent acts" or "Incompetence" case. For example, there appears to be little formal training or guidance in the Manuals about how CCU staff or Medical Consultants are to screen for "Repeated negligent acts" or "Incompetence" from what superficially might be closed as "simple departure from the standard of care" cases. Are there certain kinds of departures from the standard of care that are indicative of incompetence, or inadequate training, rather than a simple error? No answer is forthcoming from the Board's materials. Indeed, the training manuals – especially the easy-to-reference "IF/THEN" charts -- are almost entirely silent on these important issues. When asked for citations to 2234(c) ("Repeated negligent acts") in the CCU Manual, the Board identified but one, and that cite simply instructs the staff to review "prior complaints;" presumably, through checking the CAS which, as discussed, is poorly set-up to serve as the

denominator for such an inquiry. (See discussion above about the capabilities of the CAS.) Answer to Question 11, Set Two)

- It is also unclear why "simple departures from the standard of care" are not sometimes also grounds to refer the complaint to an investigator for possible incompetence under section 2234(d). Can a doctor's actions both be "departure" from the standard of care and competent? Actually, as the quote from the Kearl case above illustrates, the answer could be "yes," but it could also be "no." The Kearl case makes it clear that "While only one patient was involved, there were several acts or decisions by petitioner which were improper. This suggests more than 'a single, honest failing in performing [his] duties.'" Id. at 1956. (Answer to Question 11, Set Two)

- In sum: Where quality of care complaints from patients are concerned, the Board's presumptive "default" model seems to be to close the complaint, unless it is possibly an "extreme" departure from the standard of care, in which case it might be turned over to a professional investigator. The Board correctly observes in its supplemental answers to Questions, Set Two, that a single departure from the standard of care is not, in and of itself, a violation of B&P section 2234. But, this proves too much. Without systematic training, institutional emphasis, and basic, fact-oriented computer tracking to identify and highlight repeat offenders engaged in repeat harmful conduct, the Board's decision to forego further investigation into – indeed, routinely close -- "simple departure" quality of care complaints is significant. It means that the Board's systems and training potentially permit each "simple departure" after "simple departure" after "simple departure" from the standard of care to orbit around one another; to be viewed mostly in isolation, with the predictable unfortunate results for vigorous enforcement of sections 2234(c) ("Repeated negligent acts") and (d) ("Incompetence"). "Repeated negligent acts" and "Incompetence" are truly fact-intensive inquiries, resistant to the kind of "IF/THEN" training presented in the Manuals and recorded in the CAS ("However, since 'simple negligence' is not a violation there is no code section for tracking." Answer to Question 15, Set Two).

- In determining whether an incoming quality of care complaint should be closed before being sent to trained investigator, CCU staff and Medical Consultants are instructed to use their own discretion as to when to consult first with counsel. ("Are any lawyers routinely consulted by the CCU staff before a complaint is closed? No. Again, staff will make that determination and will, as the need arises, consult with counsel before closing a case." Answer to Question 1, Set Two) This is especially true where quality of care cases alleging a single instance of a "simple departure" from the standard of care are concerned (as discussed, those are, for all intents and purposes, ordered closed). Instead, it appears as though the Attorney General is routinely consulted only after the determination has been made by CCU to send a complaint to an investigator. (Answer to Question 43, Set One) This appears to be contrary to law. Government Code section 12529.5 (a) provides in pertinent part: " All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California . . . shall be made available to the Health Quality Enforcement Section." See also subsection (b): "Attorneys shall be assigned . . .to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations[.]" In

contrast, once a complaint has been referred to an investigation, the AG must be consulted before the investigation is closed. Section 9.10 of the Enforcement Operations manual provides that "All cases closed with or without merit by district office investigators shall be reviewed by the Deputy Attorney General (DAG) or designee at the Medical Board District offices."

- The Board responds with the following: "In the early to mid 1990s a deputy attorney general was assigned to CCU to review closed complaints. The DAG determined that after several years reviewing closed complaints the results were that CCU was doing an excellent job and that the review should be discontinued. Field office staff work closely with the DIDO during the investigation process and the DIDO's final review is to determine that the closure conforms with the DAGs understanding of how the investigation progressed." (Answer to Questions Related To The Documents Provided, page 16)

- Unlike other allegations of unlawful conduct, where quality of care complaints are concerned, there appears to be no formal requirement that the Medical Consultant or the CCU staff interview the complainant in every circumstance, or when there appears to be a conflict between the medical records and the complaint's allegations. See Sample 2 of a Statement of Services Sheet in the Medical Consultant's Manual. (This is likely in part driven by the Board's policy to close meritorious cases showing one instance of a departure from the standard of care.)[6] Instead, whether to interview the complainant is left to the discretion of CCU staff as to what is "necessary." (Answer to Question 43, Set Two)

- There appears to be no formal requirement that a Medical Consultant evaluating a complaint *must* consult with a physician expert in the relevant sub-specialty before the Consultant can recommend that the case be closed, either with merit or without.[7] Whether a Medical Consultant who is, say, a pediatrician, should be permitted to render an opinion on, say, an oncology case, is left to the Consultant's discretion. (Answer to Question 53, Set Two: "If

[6] Section 5.17, page 2 of the CCU Manual dealing with complaints against IMEs/QMEs instructs CCU staff to "Request any supporting documentation from the patient that contradicts the IME/QME report." Likewise, Section 5.10, page 4 of the CCU Manual dealing with Improper Prescribing instructs that the CCU staff is to "Secure any substantiating information from the complainant." It also provides "Refer the complaint to a Medical Consultant for an opinion whether the prescribing practice appears to be excessive. If no substantiating information is available, refer the complaint to the CCU Manager for review." As well, "If there are any concerns or questions regarding the appropriate evaluation [of a sexual harassment complaint], the matter should be discussed with the supervisor of the Central Complaint Unit." (Medical Consultant Manual, page 14) No comparable instruction was found dealing with quality of care complaints; for example, no comparable instruction was found in any manual instructing CCU staff or the Medical Consultant in quality of care cases to contact the patient, complainant, or witnesses if medical records contradict or rebut complaint information.

[7] Observe that there are 24 approved ABMS specialty boards. Observe that there only 10 specialties represented by the Medical Consultants used in the past year (Answer to Question 54, Set One)

the board's CCU or field office Medical Consultant doesn't feel it possesses the qualifications, or distinct medical knowledge, necessary to make a finding on a quality of care case, then that consultant will send the case to an expert in the specialty for review.")

E. The Board Does Not Receive All The Information To Which It Is Legally Entitled; Information That Is Essential To Its Enforcement Program.

- Section 801 of the B&P Code in part requires medical malpractice insurers to provide the Board information about medical malpractice judgments, arbitration awards and settlements. Section 803.1 requires "any malpractice judgments" be disclosed. Yet, the Board received no 801 report of the Isabel Conde case mentioned in the Orange County Register. (Answer to Question 112, Set Two) Likewise, in its own Board investigation article published in February, The San Francisco Chronicle reported: "[The Board] said it was unaware of half of the missing medical malpractice verdicts or judgements spotted by The Chronicle [.]" It also reported: "Cohen said the Medical Board can't be sure how many [awards, judgments and settlements] are missing."

- The Board responds as follows: "The Chronicle was making the point that there were judgments not posted on the website. Upon review, it was determined that the majority of these were later settled during appeal. When that occurs, the court vacates the judgment thereby erasing the verdict that allows the Medical Board to post the information on the website.[8] That does not mean that they were not reported under section 801, but that they were reported as settlements and were not subject to posting, despite a previous history of judgment." (Answer to Question 112, Set Two).

- This Answer, however, raises more questions about how the Board is interpreting the words "any malpractice judgments." First, it appears to be inconsistent with the Board's answer to Question 92, Set One: "Even if staff does receive notification that an appeal has been filed, a judgment is only deleted upon receipt of certified court documents stating a judgment has been vacated, set aside, or dismissed." For this reason it is unclear whether the Board continues to disclose judgments unless substantively overturned by an appellate court. Second, the Board will not disclose a judgment if, after it is entered, the parties afterward settle the case and, as a part of the settlement, seek to revise history and have the prior judgment "vacated." Reading the Board's answers together, it seems that under the Board's view of the words "any malpractice judgments," it is a defendant that gets to determine what is and is not reported as "any malpractice judgment." Under the Board's interpretation, "any malpractice judgment" does not necessarily include one rendered after a full trial where the defendant physician suffered an adverse verdict (i.e., where the jury "found" the "fact" of professional negligence) and where the defendant unsuccessfully moved the court for a judgment notwithstanding the verdict. A defendant can still, in the Board's view, prevent public disclosure of the fact that a judgment did exist by an after-the-fact settlement.

[8] This is not always true. A case on appeal can be settled without vacating the judgment in the trial court. It can be settled on appeal simply by dismissing the appeal, leaving the trial court judgment appealed from undisturbed.

- The Board receives very few Section 805 Reports from hospitals: just 110 in 1999-2000; 124 reports in 2000-2001. As the Board states: "There are between 500 and 600 hospitals in California. The Board has long held that these numbers suggest considerable underreporting of action taken against physicians' hospital privileges. SB 16 by Senator Figueroa, which recently became law and increases the penalty for failing to report, should encourage more reporting by hospitals." (Answer to Question 99, Set One) The importance of 805 Reports is evidenced by the fact that when the Board receives an 805 Report, it is given the highest investigative priority category: "Urgent."

F. Board Complaint And Investigative Priorities Are Questionable.

- "Urgent" complaints receive the highest Board investigative priority, but what is classified as "urgent" is open to question. The Board's "Policy and Procedure – Complaint Handling Priorities" states that "High priority complaints are to be processed expeditiously as next in order following urgent complaints." (Page 2) "Quality of Care – Patient Death" and "Quality of Care – Gross Negligence/Incompetence" cases are classified as "high priority," not "urgent." In contrast, sexual misconduct allegations or a doctor's self-abuse of drugs or alcohol are considered "urgent." (Observe, one case has defined "gross negligence" as lack of even scant care or an extreme departure from the ordinary standard of practice. Yellen v. Board of Medical Quality Assurance (1985) 172 Cal.App.3d 1040)

G. Internal Confusion About Governing Legal Standards.

- The CCU Procedure Manual instructs that B&P Code section 801 requires medical malpractice insurers to report payout information when "a malpractice settlement, judgment or arbitration award of over $30,000 has been made". (Section 5.2, page 1) However, Section 8.11, page 2 of the Enforcement Operations Manual provides that an "arbitration award of *any amount* . . . shall be reported to the MBC". (Emphasis in original. See also pages 3, 5. The latter paraphrase is the correct one)

- Page 13 of the Medical Consultant's Procedure Manual addresses medical malpractice cases. In interpreting B&P section 2234 (c) ("repeated negligent acts") the page refers to a "pattern" of departures from the standard of care. As one court observed, the word "pattern" was expressly rejected by the Legislature in the original bill that resulted in section 2234 because it was too restrictive. (See Zabetian v. Medical Board (2000) 80 Cal. App. 4th 462, 469)

- Sample letter to Complainant 5 in the Medical Consultant's Procedures Manual (dealing with complaints closed with merit: "Consultant Review – With Merit Finding") implies that the reason a complaint with merit is closed is because there is insufficient evidence to proceed under the "clear and convincing" standard for prevailing in an administrative hearing on a formal accusation. But by its very nature in a "closed with merit" "simple departure" case, the complaint meritoriously reveals a "departure" from the standard of care – that is why it can be classified as closed "with merit." Moreover, it is likely impossible to know whether the "clear and convincing" standard can be met before the complaint is sent to an investigation. As well, it does not appear as though counsel is routinely consulted at the complaint stage, and what is or is not "clear and convincing evidence" or what might lead to

"clear and convincing evidence" ought to be informed by consultation with litigating counsel.

H. Board's Public Disclosure Misleads The Public.

- As detailed in the Register, The Chronicle, and Union-Tribune articles, physicians with repeated histories of even multi-million dollar malpractice settlements could misleadingly get a "clean bill of health" from the Board's web site. This is because medical malpractice settlement information is not disclosed to the public – even though every other stakeholder insists upon the same information. (The Board obtains it for enforcement purposes; hospitals, medical groups, and medical malpractice insurers all insist upon it to weigh the potential risk of associating with particular physicians.) This is in addition to the problem of the Board not obtaining the information it is supposed to report on the web site now (e.g., malpractice judgments over $30,000; 805 Reports. See above)

- A NCSL study requested by JLSRC revealed that ten other states (Arizona, Connecticut, Florida, Georgia, Idaho, Rhode Island, Tennessee, New York, Virginia, and Massachusetts) all disclose medical malpractice settlement information. (See Appendix A hereto, brief descriptions of state settlement disclosure policies) While many physicians opposed the disclosure of such information initially, once implemented it appears as though none of these states received a noteworthy number of complaints about the disclosure from physicians. (Answer to Question 91, Set One; See also JSLRC Interviews Of Medical Boards, conducted April 26 and April 29, 2002 – Appendix B) It should be underscored that each of these states reveals medical malpractice settlement information accompanied by certain disclosures and explanatory disclaimers to place the information in an appropriate and useful context. Even more, some of them place the information in further context by providing comparative benchmarks – the average number of settlements for a particular sub-specialty, and whether the number for a particular physician is above, at, or below that average. Current California law (B&P Code section 803.1 (c)) already permits the Board to craft "appropriate disclaimers or explanatory statements included with any information released[.]"

- In 2001, the Board convened a Public Information Disclosure Committee. A sub-committee recommends disclosure of certain medical malpractice settlements with disclaimers. (See report, Appendix C)

- The Federation of State Medical Boards recommends the disclosure of certain medical malpractice settlement information.

- Misdemeanor convictions that are related to the practice of medicine are not currently disclosed by the Board. Both the Federation and the Board's sub-committee favor disclosing such information.

- There does not appear to be any correlation between the size of medical malpractice payments and the disclosure of medical malpractice settlements. Attached as Appendix D is a chart provided by the Board, using data derived from the National Practitioner Databank. Using the cumulative median payment information for 1990-2000, the lowest median

payments are seen in California (51st in rank; $41,500); Utah (50th in rank; $49,950); Idaho (which discloses medical malpractice settlements, 49th in rank; $50,000) and Colorado (48th in rank; $55,000). The top three states in median cumulative payments are all states that do not disclose medical malpractice settlements: Illinois, DC, and Pennsylvania.

- The absence of any correlation is seen if one analyzes only 2000 figures. The top seven median states for the year 2000 were: Maine (no disclosure of settlements); Illinois (no disclosure of settlements); Massachusetts (disclosure of settlements); Alabama (no disclosure of settlements); Connecticut (disclosure of settlements); DC (no disclosure of settlements) and Pennsylvania (no disclosure of settlements).

- A far better predictor of where a state ranks is whether the state places a limit on non-economic damages. California's MICRA has by a significant margin the lowest limit on such damages in the nation ($250,000) and California both in 2000 and cumulatively had by a significant margin the lowest malpractice median payment in the nation ($55,000 in 2000; $41,500 cumulatively). The other lowest cumulative states (Utah, Idaho, and Colorado) all impose non-economic damages caps: $400,000; $400,000; and $366,250 respectively. On the other hand, the top three states for cumulative median payments – Illinois, DC and Pennsylvania – both do not disclose medical malpractice settlements and do not have any cap on non-economic damages.

CONCLUSIONS

By every statistical measure, Board enforcement activity is down and has been steadily declining. Few complaints translate into Board action and, not surprisingly, dissatisfaction among those members of the public who complain to the Board is high.

The Board automatically closes most of the quality of care complaints it receives. It mostly fails to consult with the Attorney General when it does so, although the law requires such "consultation" and "assistance." The Board's complaint screening process places almost no emphasis on screening for "Repeated negligent acts" or "Incompetence." This is likely a contributing factor as to why the Board has not moved to intervene with the repeat, problem physicians identified in the press.

The Board's priorities are open to question. Some of its written materials do not reflect current law. And the Board fails or is unable to obtain information that is essential to its public protection function, and that must be sent to the Board by law.

Even when moving infrequently on the complaints it receives the Board's disclosure statutes compound the problem by impeding self-help. Those statutes hamper self-help because they fail to require the Board to inform the public of information deemed essential to every other medical stakeholders' evaluation of whether to associate with a physician. This non-disclosure disclosure program provides a false sense of confidence among patients that a doctor has a clean bill of health, when literally every other stakeholder – including the Board – may know otherwise.